Minutes of the Scottish Parliament's Cross Party Group on Chronic Pain

Held 6.15 p.m. on Wednesday 10th January, Committee Room 5

Present:

- Dr Jean Turner MSP – Convenor
- John Home Robertson MSP - Vice Convenor
- Michael Mcmenemy – Vice Convenor
- Aitkinson, Phil
- Bannister, Jonathan
- Basler, Mike
- Cadden, Helen
- Gilbert, Steve
- Grieve, Kathleen
- Hughes, Sally
- Lafferty, George
- Macdonald, Christine
- Macgill, John
- Mackenzie, Pete
- Macrae, Bill
- McNeill, Marilyn
- McPherson, Fiona
- Rafferty, Judith
- Sneider, Anthony
- Stuckey, Nicola
- Thompson, John
- Wallace, Heather
- Wilson, Gillian
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Apologies

- Corcoan, Judith
- Craig, David
- Elder, Dorothy Grace
- Falconer, David
- Hester, Joan
- Jones, Derek
- Kalman, Lynne
- Lynas, Dorothy
- Mewed, Jim
- Mills, Bernard
- Mills, Sandra
- Norden, John
- Quadros, Paulo (inserted later)

- Quinn, Ruth
- SALV (Psoriasis Scotland Arthritis Link Volunteers)
- Scanlon, Mary
- Simpson, Martin
- Smith, Blair

1. **Minutes of last meeting**
    1. **Mike Basler:** Regarding paragraphs 83 and 89, it says it is the proposal that Mike put on the table. Clarified that it was not his proposal but he was relaying the proposals from the executive and from NHS QIS.

    2. With these corrections the minutes were proposed by Mike Basler and seconded by Nicolas Stuckey

2. **Matters arising**
    1. **Letter from Jean Turner to Andy Kerr** asking if he could come. Jean Turner said he sent apologies and this letter. Everyone should have a copy of it.

    2. **Dorothy Grace Elder's proposal that a letter be sent from the cross-party group to the minister and first minister.** She suggests this should be a strong letter saying we are disappointed that little has been done for chronic pain in the two years since the executive first expressed sympathy. The Mewed report was commissioned but not implemented; a consensus conference was held by the executive but no action resulted. To the public this looks like being let down severely. We remind the executive that this campaign originated directly from the public. 130,000 people contacted the parliament expressing hope that action would be taken -- a record number. Pain sufferers will see the fact that other chronic conditions are being reviewed as an excuse for more delay. Chronic pain remains Scotland's biggest health issue in patient numbers. It is impossible to explain why nothing really visible or effective is being done nationwide in response to public demand.

    3. Jean Turner said we could write a letter after this meeting.

3. **John Thomson:** After 6 years we are no further forward. Don't need more audits or more talking. We are due this.

4. **Helen Cadden:** At the consensus conference we were so much hoping that something would happen. Nothing has happened. How many more times do we have to ask? We are not getting anywhere.

5. **Jean Turner:** What do you think about the Long Term Conditions Alliance Scotland? Should chronic conditions initiative be kept as a separate issue?

6. **Helen Cadden:** Separate issue. Chronic pain needs to be recognized as a syndrome in its own right. It can't be put along with MS or cancer services. We need to have chronic pain under its own banner.

7. **Gerald Lafferty:** My point is about the physiotherapy department in Glasgow Royal. The public perception is you can walk in off the street into the physiotherapist and get assessed. That's not what is happening. You've got to phone up. There's only two days a week you can get seen. I sufferer from ankylosing spondylitis which is a chronic condition. The way the service works affects me. People walking in off the street with acute pain and injuries get seen before me. I am actually put back further on the waiting list if I say to Glasgow Royal I've got a flare up, because they know I'm a chronic condition. It's because they don't have the staff

8. **Michael Cheney:** There are two things here. One is the lack of education. They don't recognize that even though Gerry has had these problems for a number of years, an acute flare up should be treated as an acute problem and treated straight away. The back pain service and Physiotherapy Pain Association will be giving training for a hundred physiotherapists, recognizing that very thing. Secondly, there is a resource problem in physiotherapy departments. In Shettleston, a routine patient would wait 25 weeks to be seen.

9. **Gerald Lafferty:** the patients got money off the lottery and used it to buy equipment for the gym in the Glasgow Royal. They have to buy equipment to help with their own condition!

10. **Nicolas Stuckey:** if we are going to write to the Minister an important point to make is about the take he took when he came to our meeting the last time, which is that chronic pain needs to come under the umbrella of long term conditions. That has already been recognised or spoken about tonight. It is echoed again in the minutes from the Long Term Conditions Conference. We may want to say that while we understand why it is cited in that way in the Kerr report, in our local health board it means that chronic pain gets buried. We need to say that chronic pain needs to be seen as a condition within the context of long-term conditions. It has different needs from some of the other conditions.

11. **Bill Macrae:** At the conference on the Mewed report I gave a resume of all the reports. I made the point that all the recommendations were just the same. If politicians didn’t give attention to the reports that they had commissioned people were going to get cynical. In this letter from Andy Kerr, he is once again sliding out of any commitment to do anything. After the last meeting I wrote to Andy Kerr about the Inverness problems. I got a reply from a civil servant that was pathetic. I have replied to the reply. I have not had a reply to that.

12. **Jean Turner:** He is leaving it up to the health boards if they have the money. Jean Turner asked Mike Basler about the ACADs

13. **Mike Basler:** There are 2 separate issues.

    1. How are we going to reorganise the clinics at Glasgow? We are going to coalesce clinics so there will be a 9 to 5 Mon to Fri pain clinic in north and south at both ACADs. That is dependent on the ACAD timetable. There have been delays with ACADs, with funding and structural problems with building works.
    2. *Glasgow pain management programme*. There is funding and people are being employed to run a pain management programme for Glasgow, so patients will not have to go to Astley Ainslie Hospital. Right now there is a problem with the building. There are moves to use the cardiac rehab unit at Stobhill. We hope that a West of Scotland pain management programme will be up and running soon.

14. **Gavin Gordon:** Building work has started at Stobhill (north) and at Victoria (south). 2009 is completion date for ACADs. The process of employing and training staff for the pain management programme has started. There is a search to secure a suitable room.

15. **Mike Basler**: There has been a pain management programme at Astley Ainslie for 13 years. People have had to travel to that from Glasgow. Now through this group and other pressures made, we have got funding for a pain management programme. We want a strongly worded letter but we need to be very focused or Jack McConnell will say I have just funded a pain management programme, and you are telling me that we have done nothing and you have been let down.

    One thing has been done. This project was shelved but then pressure was put to bear that it should happen. Yes, have a strongly worded letter. Bill's particular concerns are the area we should focus on the "bereft" service in NHS Highland and on Lanarkshire and Borders. How are they going to fit in as other services are developing? Otherwise we will get a letter back saying we have done this and that. It gets rid of your argument.

16. **Helen Cadden:** We have that. But in NHS QIS there will be another scoping exercise and standards will take 4 years. As patients we can't wait.

17. **J Home Robertson:** Mike 's advice is wise. Always remember you are trying to persuade people to do things. It is the easiest thing in the world to fire off strongly worded letters and put out press releases. You might get a headline one day but the reaction among the people you are wanting to influence might be "blast them, I am trying to help and I am just getting dog's abuse. What's the point of helping these people?" You are making a bit of headway here. Pain is a terrible thing. People

are suffering. We need to address this as quickly as it is humanly possible. But we are trying to get solutions. When drafting a letter focus on things that can be achieved by people working in a cooperative way. Push them in that direction and make it easier to get solutions. Make a point about equity of access to service.

18. **Pete Mackenzie:** It would be useful to pin him down about what exactly does he mean by "I would want to ensure that this piece of work can be delivery proofed"? What mechanisms would he put in place? How does he think the recommendations that come through NHS QIS are going to be implemented and funded?

19. **Gavin Gordon:** The standards should come first then the resources should follow, not the other way round. That statement is ambiguous. The ambiguity needs to be removed. Also, we have 3 positive suggestions tabled already.
    1. We want chronic pain recognised outside of the umbrella of chronic conditions.
    2. is about NHS QIS.
    3. is if we could get recognition in primary care that pain is something that should appear on the contracts that would materially help matters.

20. **Michael Cheney:** John Home Robertson makes a good point. You are trying to persuade people to exert influence and change things. However, this morning I had a call from a woman who lives in Lothian. 2 years ago, I was asked to speak to a patient group about Greater Glasgow Back Pain Service. I described how given a small resource we could transform the pathway for a lot of patients with a significant problem – low back pain that includes chronic pain. This woman was asking about a Lothian Health Board group set up on back pain. 2 years ago, it was to have stakeholder meetings. They didn't happen because the group couldn't engage the GPs and nothing has happened since. That is disgraceful. There is a model that works. It is not expensive. Simply the health board in Lothian lost interest.

21. **Nicola Stuckey:** It highlights the problem of there being no strategic planning within health boards for this. It has got lost because it doesn't fit into any particular strategy and there is nobody taking responsibility at board level. If we are going to put anything else into the letter it would be about boards having strategic responsibility for planning for chronic pain services and also picking up John Home Robertson's point about the equity of access to services

22. **Heather Wallace:** We do have to come under the Kerr report. It is as well to acknowledge that chronic pain is a chronic condition. Pain can be a symptom of a condition and it can be a condition in its own right. How will it come across if you say it isn't a long-term condition fitting within the Kerr report?

23. **Nicola Stuckey:** It is a long-term condition but if service planning only allows it to be subsumed under the generic umbrella of long term conditions then we lose the detail of the sorts of things we are talking about here.

24. **24.Jean Turner**: Many illnesses have chronic pain as part of their condition but you would go to a specialist clinic for the pain. It is important to make that distinction in the letter.

25. **Mike Basler:** Everyone realises everyone's frustrations. Rather than saying we've had enough, we need to take a long-term paced approach, a. determined approach that doesn't let go. Because the audit comes under the auspices of NHS QIS, boards have to answer the questions absolutely, e.g. do you have someone on your board at strategic level? Straight away we get an answer. We will have that answer for every board in every region in Scotland. That data is owned by the executive unlike other audits, e.g. Dr Foster. It is easy to say it was data from a drug company. The work that is being undertaken is to be finished by April 2007. It is to be under the auspices of the executive or a sub group of the executive so there shouldn't be the gaps etc that we are worried about.

26. **Helen Cadden:** We aren't going for the quick fix. We thank you for time and dedication you have given. We would love to be pain free. I can't remember what that was like. Six years is a hell of a long time to wait in pain.

27. **Steve Gilbert:** The amount of suffering people go through before they get to specialist pain services - and GPs lack of education means they have to see a pain specialist - is something we want to highlight in our letter. I notice the chronic pain policy coalition in London is mentioned at the end of the agenda. The executive can apply pressure to the health boards and the health boards can say we need to get our waiting times down. They have cuts in waiting time coming up again. I thought a Chronic Pain Policy Coalition of patients and professionals outside the parliament might be an effective way of campaigning direct to the press, to boards and to name and shame people like Highlands.

28. **Jean Turner** will draft a letter. People can give me phrases to include. There is an FMQ from Janice Johnson from SALV regarding patient representation. We can write a letter to Harry Burns to ask what groups he has already spoken with.

29. **Heather Wallace** has circulated report on LTCAS Self Management Conference. Speakers were Andy Kerr, Audrey Birt, LTCAS chairman, Angela Donaldson, chief executive of Arthritis Care. Audrey Birt called for more clinical psychology, also echoed round this group. Self-management programmes are being rolled out. Some cover pain. The Expert patient programme in England has developed an add-on

module for pain It's important that the right patients get to the right programme for their needs and that self management programmes aren't seen by Boards as a cheap option. Angela Donaldson is willing to speak to the group about the self management programmes if that would be of interest.

NHS QIS

30. **Nicola Stuckey:** Under auspices of NHS QIS we have set up a national chronic pain benchmarking group. It feels slow but it will be a detailed exercise to ask clear, searching questions of every health board. It is a short life group, the 1st stage of setting up standards, and then implementing services in relation to the standards. Members of the group include Blair Smith to represent primary care and Jan Warner, director of NHS QIS. The group's function is to supervise the national chronic pain benchmarking exercise, oversee the progress of the project; contribute to the structure of this questionnaire, which is almost finished now. The questionnaire will be sent to every NHS board. It asks about services in detail and about issues such as where does chronic pain fit in the strategic planning. It will not just be about what Boards say they do but about what patients say they experience. Following that exercise, we will put together a report by the end of April. It is slipping a bit but we are working hard to get it out. In order to work quickly we have formed a small group but there will be a wider reference group, to whom we will report monthly. We are in process of putting names together for the wider group, e.g. Scottish Executive, the Royal Colleges. Let us know if you would like us to include people in that wider reference group. We will give a brief electronic report of the activity rather than a report for consultation. In terms of representation from patients, the decision was made to approach somebody through the NHS QIS patient partnership. That isn't necessarily how we would envisage things for the future. At end of April, the report should show clearly where the gaps in service are in Scotland. The issue of equity will be highlighted and good practice. We can use that as much more clear cut ammunition to follow from some of the points that have been made already.

31. **Jeanette Barrie:** Dr Foster Report = only 4 health boards in Scotland responded to the Dr Foster Report. Ours is a very detailed questionnaire. A person within each board will be identified to complete the questionnaire, and the chief executive must sign the questionnaire off before it is returned. There is a 3-tier approach to this project. Once we have the responses from the boards, we will test the responses by undertaking focus groups with health professionals from pain services and health professionals who access pain services. This will identify gaps within primary care, secondary care or tertiary care. An independent consultant, expert in focus group facilitation and analysis, will carry it out. Tier 3 will be to validate tiers 1 and 2 by undertaking patient focus groups. We will get patient experiences of trying to

access services and of going through services. A comprehensive report and action plan delivered to the minister by end April 2007.

32. **Michael Cheney:** is concerned that the only representative of primary care is Blair Smith. 90% of patients are seen in primary care and that has to be reflected in the questionnaire. To illustrate, physiotherapists in Highlands are not able to get patients referred to a pain clinic. There are no/few services and traditionally physiotherapists can't refer to pain clinics. We could open up that pathway with certain discussions but only if you ask the other health professions in primary care. Practice nurses, occupational therapists, and physiotherapists, need to be actively involved in this.

33. **Jeanette Barrie:** There will be focus groups within primary care. There will be 6 within acute sector and 6 within primary care looking at all regions within Scotland.

34. **John Bannister**: Is end of April realistic for qualitative research?

35. **Jeanette Barrie:** that is the timescales we have been given.

36. **Nicola:** We will try our hardest to do that. To some extent that will depend on the speed at which health boards respond.

37. **Steve Gilbert:** Are you going to identify a champion for this audit in each hospital, which could be the lead clinician in pain or in Highlands the clinical director of anaesthetics? And they would be able to chivvy the executive.

38. **Pete Mackenzie:** We have a group of professionals who are directly involved with chronic pain services throughout Scotland negotiating with NHS QIS about the questions being asked and also about the way in which the project is carried out. I don't think all has been thrashed out yet. We have got a meeting at the end of January in order to do that. There are issues regarding the questions and strategy we adopt to make sure it gets done efficiently, effectively and we get the answers we are looking for as quickly as possible. I was very encouraged when I attended the meeting with NHS QIS. I think it is a comprehensive look at services across Scotland. We are looking at primary care but we have to have a sensible set of questions so it is not too cumbersome a project that is goes on and o

39. **Gavin Gordon:** My question is do NHS QIS have the teeth to ensure do respondents do respond within a certain deadline If there is any doubt about it could we not ask the minister in our letter to make sure that they do respond within a certain deadline.

40. **Mike Basler:** That is a key thing.

41. **Bill Macrae:** Can I raise a note of caution? I got an angry phone call from Highland Health Board saying I was telling lies about them not responding to letters. I gave them all the details and they had to give me an apology. Our medical director has written to them many times. They don't even respond to our letters. There is no will amongst the relevant clinicians or Highland Health Board to do anything about this. They think Tayside and Grampian will see their patients for nothing. That is what is happening.

42. **Mike Basler:** Our experience with Lanarkshire and with Argyll and Clyde has been similar. With this audit, the focus groups will highlight the problem that a GP can't get hold of anybody who is interested; they will show what the patients feel. That is going to be per region. There is a set of questions and 2 follow up mechanisms by which the GP will say, "in my experience this is what happens". It is going to be in the acute sector but also in the primary care sector and it is going to ask patients. So on 3 levels as well as at board level people's voices will be recorded. Whether that is actually heard in terms of resources is the other thing we are looking at down the line, but at least there is a mechanism by which someone's frustrations can be reported.

43. **Bill Macrae:** Can I strongly support the idea that someone in authority leans on these health boards and says you have got to respond within a time scale because I will predict that Highland health board will not respond.

44. **Jean Turner:** Have you had experience of people turning you down?

45. **Jeanette Barrie:** I can't speak for the whole of NHS QIS but not in my experience.

46. **Pete Mackenzie:** Jan Warner who chairs the group has indicated a likely timescale of the development of standards. It is probably going to be this year. We have done extremely well to get NHS QIS to agree to taking on chronic pain standards ahead of those for intensive care. I think that is something we should all celebrate. If the likely timescale for the visits that follow the standards is approximately 12 months later, with a bit of slippage, we are looking at 2008. If that information gets circulated around the country to hospitals and health boards that will apply some pressure. I wonder if we could be a bit more positive about the impact that this process might have. I know that historically things have not happened but in this case, there might be a subtle difference. It is happening through a body that is independent but very much linked into the executive.

47. **Nicola Stuckey:** It would be helpful to have the minister's clout behind it. I am sure what is likely to happen is what happens with many things with health boards. The paper comes into somebody's desk - it sits there for 2 weeks They realise the deadline is 2 days hence and you

get a frantic phone call saying you have to give me this information instantly.

48. **Mick Cheney:** It is brilliant this has been put higher on the agenda but it is reasonable that we comment about the process just now. NHS QIS are doing a health technology assessment in relation to back pain services. I have been working with them for about 18 months. The report, which might recommend that the model in Glasgow be easily replicated, should be due in June 2007. But they were going to send out questionnaires through the health boards across Scotland about current services. Physiotherapists don't have a clue what health boards are and health boards don't know what physiotherapists do. Why not use the skills and organisation around this table and maybe use a simple questionnaire that you could send out to all the doctors in pain clinics, GPs, physiotherapists and nurses in Scotland and get some feed back from people who do work with patients.

49. **Mike Basler:** If you are asking about timeframes and this letter you are talking about next year or the year after. That is clearly not feasible.

50. **Michael Cheney**: We designed a training programme for physiotherapists; training needs analysis about pain management. It was put on a website and advertised to all the physiotherapists through our professional body and it was done in a month.

51. **Pete Mackenzie:** We have got to thrash out methodology and strategy and to discuss who we ask the questions of. I have concerns about targeting individuals within the health boards. Maybe by targeting lead clinicians – people involved with service delivery - you might get a quicker response and more detail. If you target a clinician from Highland health board, it will be a quick job because there is no service. As long as there is pressure to return the form, we should get information. That information is useful even if it is just to say "no service".

52. **Fiona McPherson:** Are the focus groups going to be made up of different people, nurses, physiotherapists, etc?

53. **Jeanette Barrie:** We have still to look at that in detail but it will be nurses, doctors, physiotherapists, and occupational therapists from both the acute sector and primary care.

54. **62.Fiona McPherson:** I worked as a district nurse in Highland for 4 years. I know what happens in Inverness where the health board is. It is a world away from the main area so it is important to get people's views. I have been asked to go up there and speak about chronic pain but I was asked by the nurses not the GPs.

Managed clinical networks

55. **Mike Basler:** A managed clinical network isn't anything in terms of resources. It is an organisational way of working that crosses health board boundaries to try and disseminate best practice. It could be just another bunch of words just like this audit could be. We recognise that. But it is integral to what the health board and the executive have said is their way of pushing forward the management of conditions, particularly long term conditions, in the future. There was an offer at the consensus conference of a pilot MNC for chronic pain. It amounted to £50,000 for 2 years for a manager's salary. It provoked anger, but it was an offer of something we did not have. It was decided that West of Scotland might be a suitable place. The difficulties with cross boundary flow and the impact that has on services would be ironed out with this. In Pete's clinic and in Gavin's clinic the budget and waiting list were blown by patients coming from Argyll and Clyde and from Lanarkshire. There was a hope that we could provide some kind of network that would incorporate Argyll and Clyde and Lanarkshire. There were discussions at Board level that I was not party to. A document was put to the regional planning group. Glasgow health board did not want to take on Lanarkshire due to the current difficulties. They thought it would be neater and easier just to include Argyll and Clyde. As far as I can gather, Andy Kerr's letter confirms this; Glasgow has bid for this. There have been representations from the clinicians to include Lanarkshire but at Board level, these have not met with favour. So from this letter and what we understand a bid has been put forward and accepted to pilot this way of working together. It is not prescriptive thing. It is not saying that the way the West of Scotland works has to be applied everywhere else. It is looking at is a generic way of working together, a useful way of organising services. Importantly from our point of view, we know it is what the executive and the boards want to do. We have a better change of getting money and resources from them if we go along with that. As far as we know Lanarkshire is not included in the bid. A manager will be put in place at some time in the future.

56. **Gavin Gordon:** A managed clinical network is really an informal way of working made formal. The executive describes it as a clinically managed network. The pluses are that it depends on primary care involvement and that it should ensure equity. On the down side it is a 2 year pilot so you are not going to get immediate results and Scottish wide implementation. There are areas outside but adjacent to Glasgow where resources are fewer than we have. This is not a way of getting resources into "deprived" areas.

57. **Steve Gilbert:** Are you then going to refuse referrals from Lanarkshire or are you going to carry on seeing them, but spread everything thinner?

58. **Gavin Gordon:** You are voicing concerns that we have made to our health board: that this is not a dilution; that this has a very clear remit; that we are not going to forsake our own patients to help others. We

are not going to diminish our own standards so that other people can reach a better level.

59. **Mike Basler:** If this way of working did provide beneficial we would want to ask in the letter to the minister for a guarantee that other areas where there are major difficulties would be able to take part in the same type of process if they so wished.

60. **Michael Cheney:** Is the MCN going to include Argyll and Clyde or is it going to be just Glasgow?

61. **Gavin Gordon**: I don't know.

62. **.Jeanette Barrie:** Lanarkshire have a working group looking at chronic pain services. They are putting together a business plan.

63. **Pete Mackenzie**: Negotiations are underway with health boards adjacent to Glasgow health board, to make sure resources follow referrals. Negotiations will take place at regional planning level to deal with cross boundary flow, e.g. referrals for spinal cord stimulation but not referrals for pain management programmes which is going to be a separate issue. We are trying to do our best with the people we are working with at the health board. The pluses of keeping an MCN in Glasgow might be to show that an MCN can work successfully.

64. **Judith Rafferty:** After Mewed report did the minister not say that the Boards would be asked to respond as to how they would move forward?

65. **Mike Basler**: He did and he presented that to us at the last meeting. The Deputy Chief Medical Officer said she was going to chase up 2 health boards that hadn't responded. She had been given short shrift from some health boards.

66. **Judith Rafferty:** That is the point I want to make in our letter to the minister asking for clout for boards to answer QIS. If that has been done before, how can he ensure NHS QIS gets responses?

67. **Mike Basler:** I want to make concluding point: we have said to Glasgow that we wanted to include Lanarkshire because there is a huge service need and GGHB have said no.

68. **Gavin Gordon:** I am a fan of Manes. Wherever it goes it offers an opportunity to give a better deal to patients. I am just unsure what it is Glasgow has bid for.

69. **Jean Turner:** The minister's letter reads as if it all depends on GGHB playing ball. .

70. **Gavin Gordon:** That is a standard way of establishing these networks. Glasgow has bid for it so they will sign up for it. I wouldn't be too concerned.

71. **N Stuckey:** My experience of an MCN is it doesn't come with resources. It is about redesign. They may well be asking Glasgow to sign up for continuing administrative help but not necessarily ensuring that there are the resources that are needed for services.

72. **Mike Basler:** It is like changing from a Burgerland to a franchise. You adjust to a different way of working. It is still a Burgerland with a MacDonald's sign – it is not much better. But if you become the franchise that the whole process is involved in then it might actually be better.

73. **Heather Wallace:** Do you want the cross party to do anything about it. Do you want Jean to write to GGHB?

74. **Mike Basler** I would ask the minister to clarify and to ask Glasgow why they felt Lanarkshire shouldn't be part of this.

75. **Gavin Gordon:** We are due to have meeting with Glasgow Health Board at end of this month and I hope there will be clarity about this following that meeting.

Economic Case of Pain Management

76. **Marilyn McNeill: -**Members will recall that at the last meeting the issues of cost savings from identifiable outpatient services for chronic pain came up a number of times. A figure of £1000 savings per patient was mentioned which was derived from the Mewed report .We tracked that down to the report that was mentioned by Steve Gilbert – *the Health Technology Assessment Systematic Review of outpatient services for pain control* by McQuay who mentioned and utilised the data, the results and methodology in a paper by Weir/Waddell from Hamilton in Ontario, Canada. They analysed the direct health care cost to a sample of 222 patients who either attended of didn't attend a chronic pain clinic. The people who didn't attend were almost a self-selected control group. The analysis did control for some differences between the 2 groups. McQuay extrapolated from this methodology, using the figures to cost of running the Oxford pain relief unit in 1982. They identified savings of £1117 per patient, which was twice the running cost per patient. We spoke to Amanda Williams one of the authors of McQuay Waddell report. She said she wasn't aware of any more recent cost effectiveness or economic analysis of pain clinics. We then moved on to the CSAG report about chronic pain in Scotland. There is an annex of this: the *Epidemiology and the Cost of Back Pain.* This was difficult to track down and we are just getting a hard copy of it. I am sorry we don't have those results to include in the report but I did speak to Gordon Waddell about this. He said he would be loath to extrapolate from the data. He said it was now out of date. So overall,

there is not a strong economic case at this point. A lot more research needs to be done.

77. **Jean Turner-** asked Mike Basler about figures he had used in a talk he had given to the group.

78. **Mike Basler:** This was from Wesley's group in Maudsley, London about frequent attenders at 2ndry care clinics. If we look at a recent paper about the expert patient programme which was published in BMJ a month ago it showed no economic benefit. If we look at a recent paper in case management, again it showed that the economic case was not clear-cut. We need to be careful. What it shows is that this is something that needs to be taken on

79. **Marilyn McNeill:** It is begging for more research. If things are to be set up then to build in evaluation that included some kind of cost analysis / quality of life as an indicator would be valuable

80. **Nicola Stuckey:** We did a small pilot study funded by the Scottish Executive looking at the viability of collecting data on health economic aspects of pain services. We included things like attendances at local authority OT services and physiotherapy referrals. It was about the mechanics and practicality of undertaking a study of this kind. You would be welcome to look at that.

81. **J Bannister:** Do we really need an economic case? Is the minister going to turn around and say a) I don't believe in chronic pain and b) I don't believe in treating it? Pain is such a diffuse thing, even McQuay and Waddell can't get hard data and they are very good. Is chasing the costs worth the effort?

82. **Jean Turner:** It is about quality of life.

Primary Care Practice

83. **Pete Mackenzie:** Dr Martin Simpson is willing to attend the cross party group. He is not able to provide data on his project now but will be able to do this by March.

84. **John Bannister: SCM – Scottish Medicines Consortium** 3 recent formulations of medicines have gone to SMC recently for pain. They have been refused or not recommended. I am aware that pain is a low priority on SMC's radar. They don't seem to understand how difficult it can be to find the right drug for a patient in pain. We don't have a big impact on them. Within the core groups of SMC, there is nobody with any major pain experience. They now use people from outside, e.g. myself and Mike Serpell for outside expertise, but they make some strange decisions. They are not doing themselves, patients or their doctors any favour. There are little pitched battles between primary care and secondary care to get certain drugs prescribed for certain patients. If you are in the right practice you will get the drug. If you are

in the wrong practice a pharmacist will say it is not on the list – we are not prescribing it.

85. **Jean Turner** Put this on paper and we can write them a letter.

86. **Gavin Gordon:** The key to it is to get someone in the core group.

Dorothy Grace Elder's request to liaise with Chronic Pain Policy Coalition.

87. **Nicola Stuckey:** I was at launch. Heather Wallace was there. They have some things to learn from us.

88. **Heather Wallace:** They are doing useful work e.g. with industry and Crops. Agreed to contact coordinator of CPPC to explore link.

RCGP representation on Cross Party Group on Chronic Pain

89. Heather Wallace: Sent information about cross party group to the RCGP in Edinburgh. They asked if the cross party group had any funds to pay a GP to take time out to attend the group.

AOCB
Mary Scanlon

90. **Mike Basler: The** NBPA accepts Mary Scanlon's thank you for the flowers (sent when she left parliament)

Quality Outcome Framework (QOF)

91. **John Bannister:** A member of RCGP has recommended we lobby to get pain on the Quality Outcome Framework. Other Groups bombard Mike Winter's QOF group to get their condition on QOF. Pain might not get there first time but if we don't ask, we certainly won't get there. Can I encourage patient groups to write to MSPs to get pain on QOF – asking for pain on every GPs computer? I was told informally that the RCGPs would add their voice to that.

92. **Jean Turner**: This group could write.

93. **Heather Wallace:** Would this member be RCGP's rep on this group?

94. **J Bannister:** I can ask if there is someone.

95. **M McNeil** drew attention to the modernisation strategy, which is out for consultation and is another route. One of the tenants is to improve the data collection.

96. **Nicola Stuckey:** There is a Lothian modernisation strategy. It is worth everyone looking at their own health board area to see if there is a modernisation strategy they can feed into.

Michael McMenemy's appointment as Vice Chairman

97. **Heather Wallace:** Tony Reilly at standards office has confirmed this appointment made at AGM.

Meeting ended at 21.00 hours.
The Convenor thanked **Medtronic** for sponsoring the refreshments